Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address: Ajay K. Bindal, MD 7737 Southwest Freeway #230 Houston, TX 77074	MFDR Tracking #: M4-06-7249-01 DWC Claim #: Injured Employee: Date of Injury:
Respondent Name and Box #: City of Houston Rep. Box #: 42	Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary as stated on the Table of Disputed Services: "Incidental to primary procedure."

Principle Documentation:

1. DWC 60 package
2. Total Amount Sought - $1,271.50
3. CMS 1500s
4. EOBs
5. CCI Edits
6. Operative Report

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: Respondent did not submit a position summary with their response.

Principle Documentation:

1. Response to DWC 60

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
10/17/05	CPT Code 63030-50-59 ($927.83 x 125% = $1,159.78 x 50%)	97, B15, W1	1, 2, 4, 5	$ 579.89
10/17/05	CPT Code 63030-50-59 ($927.83 x 125% = $1,159.78 x 50% = $579.89)	97, B15, W1	1, 2, 4, 5	$ 310.59
10/17/05	CPT Code 61975 ($271.10 x 125%)	97, B15, W1	1, 3, 4, 5	$ 338.87
Total Due:				$1,229.35

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.202, titled *Medical Fee Guideline* effective August 1, 2003, set out the reimbursement guidelines.

1. These services were denied by the Respondent with reason code "97 – Charge included in another charge or service"; "B15 – Procedure/Service is not paid separately"; and "W1 – Workers' Compensation State Fee

Schedule Adj."

2. CPT Code 63030-50-59 – According to Division Rule at 28 Texas Administrative Code (TAC) Section 134.202(b) modifiers -58 and -59 are allowed and will bypass the Column1/Column 2 edit. Therefore, per 28 TAC Section 134.202(c)(1) reimbursement is recommended at 50% of the MAR amount or the health care providers usual and customary charge is recommended.
3. CPT Code 61795 – According to Division Rule 28TAC Section 134.202(b) this CPT Code was a component procedure of CPT Codes 63030 and 63012; however, this edit has been deleted retroactively to its effective date of 09/05/2000 making the edit pair not active. Therefore, per 28 TAC Section 134.202(c)(1) reimbursement at 50% of the MAR amount is recommended.
4. Per review of Box 32 on CMS-1500, zip code 77074 is located in Harris County. The maximum reimbursement amount, under Rule 134.202(b), is determined by locality.
5. Per Rule 134.202(d), "reimbursement shall be the least of the (1) MAR amount as established by this rule; (2) health care provider's usual and customary charge; or (3) health care provider's workers' compensation negotiated and/or contracted amount that applies to the billed service(s)." The lesser of these three amounts was the MAR amount as established by this rule on the first item listed on the Table of Disputed Services and also was the health care providers usual and customary charge and identified on the second item listed on the Table of Disputed Services.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

- Texas Labor Code Section 413.011(a-d);
- Texas Labor Code Section 413.031;
- Texas Labor Code Section 413.0311;
- 28 Texas Administrative Code Section 134.1;
- 28 Texas Administrative Code Section 134.202; and
- Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is entitled to reimbursement. The Division hereby **ORDERS** the Carrier to remit to the Requestor the amount of $1,229.35 plus applicable accrued interest per Division Rule 134.803, due within 30 days of receipt of this Order.

ORDER:

Authorized Signature	Auditor III, Medical Fee Dispute Resolution	June 12, 2008 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.